STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals and
Eaton County Circuit Court - Hon. Calvin Osterhaven

ADVOCACY ORGANIZATION FOR
PATIENTS & PROVIDERS, et al

Plaintiffs-Appellants

Supreme Court No. 124639

vs.

AUTO CLUB INSURANCE ASSOCIATION, et al

Michigan Court of Appeals
No. 231804

Defendants-Appellees

Lower Court No. 96-001409-CZ

_____/

BRIEF OF AMICUS CURIAE
MICHIGAN STATE MEDICAL SOCIETY

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STATEMENT IDENTIFYING BASIS OF JURISDICTION

Jurisdiction exists in this Court pursuant to MCR 7.301(A)(2) and MCR 7.302. This Court granted leave to appeal by Order dated June 25, 2004, which also invited "persons or groups interested in the determination of the questions presented" to move for permission to file briefs amicus curiae.

Amicus Curiae Michigan State Medical Society supports Plaintiffs-Appellants' request for reversal of the July 3, 2003 decision of the Michigan Court of Appeals in *Advocacy Organization for Patients & Providers v Auto Club Insurance Association, et al,* 257 Mich App 365; 670 NW2d 569 (2003).

STATEMENT OF QUESTION PRESENTED

Should this Court reverse the Court of Appeals' decision which interprets the "reasonable" and "customary" charge language of Section 3157 of the Michigan No-Fault Automobile Insurance Act to allow an insurer to unilaterally determine that a charge is unreasonable and to base that determination on an 80th percentile system that is tantamount to a maximum fee schedule?

Plaintiffs-Appellants say "yes."

Amicus Curiae Michigan State Medical Society says "yes."

Defendants-Appellees say "no."

The Circuit Court would say "no."

The Court of Appeals would say "no."

INTEREST OF AMICUS CURIAE MICHIGAN STATE MEDICAL SOCIETY

Michigan State Medical Society ("MSMS") is a professional association that represents the interests of over 14,000 physicians in the State of Michigan. In this capacity, MSMS has frequently been called upon to express the views of its members relative to matters of interest to the health care community. The issue presently pending before this Court, relating to an insurer's obligation to pay the reasonable and customary charges of health care providers pursuant to Sections 3107(1)(a) and 3157 of the Michigan No-Fault Automobile Insurance Act ("No-Fault Act"),[1] presents such an issue.

On cross-motions for summary disposition, the Trial Court held that Defendants were entitled to review the medical charges of no-fault providers and pay only those charges determined to reasonable.[2] The Michigan Court of Appeals affirmed. *See Advocacy Organization for Patients & Providers v Auto Club Insurance Assoc,* 257 Mich App 365; 670 NW2d 569 (2003). Identifying the "dispositive issue" as "whether, under the language of the act, defendant insurance companies are required to pay the full amount charged as long as the charge constitutes a 'customary' one, or if defendants are entitled to independently review and audit the medical costs charged to their insureds to determine whether a particular charge is 'reasonable,' " the Court of Appeals ruled that Defendants could decide whether a charge was reasonable by determining whether it exceeded the charge of 80% of other providers rendering the same service, and then pay only an amount that did not exceed this "80th percentile" charge.

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[1] MCL 500.3101 *et seq.*

[2] Based on these conclusions, the Trial Court also held that Plaintiffs failed to establish claims for tortious interference, civil conspiracy, and fraud.

MSMS' members routinely treat patients whose medical expenses are paid through the personal injury protection benefits of their automobile insurance policies. MSMS believes that the Court of Appeals decision is contrary to the reimbursement requirements of the No-Fault Act and conflicts with other prior Court of Appeals' decisions. On behalf of its members, and for the reasons discussed below, MSMS urges this Court to reverse the decision of the Court of Appeals.

STATEMENT OF FACTS

MSMS relies upon the Statement of Facts contained in Plaintiffs-Appellants' Brief on Appeal.

SUMMARY OF THE ARGUMENT

The plain language of the No-Fault Act unambiguously allows a health care provider *to charge* a reasonable amount for services rendered, not to exceed the *provider's customary charge* in cases not involving insurance. MCL 500.3157. The Act gives the insurer no express role in determining the provider's charge. Yet, under the guise of the requirement that the charge must be "reasonable," the Court of Appeals has held that an insurer may pay according to its own schedule of charges derived from an "80th percentile" scale that is based on the *charges of other providers*. This result unquestionably contravenes the statute and the clear direction of numerous Court of Appeals cases that have repeatedly rejected attempts by no-fault insurers to impose Medicaid, Workers Compensation, and other maximum fee schedules on providers of no-fault benefits. *See* pp 4-8, *infra*.

The effect of the Court of Appeals' decision is to permit insurers to pay health care providers according to unilaterally imposed maximum fee schedules similar to those contemplated in legislatively-enacted No-Fault amendments that were *rejected by Michigan*

voters.[3] If the Act, as presently constituted, permits insurers to pay provider charges according to maximum fee schedules, the Legislature would not have deemed it necessary to amend the No-Fault Act to so provide.

Under the guise of statutory construction, the Court of Appeals' decision directs a fundamental change in the thrust of the provider reimbursement provisions. In doing so, the Court of Appeals has exceeded its authority. The *Advocacy Organization* decision should be reversed.

ARGUMENT

I. THE ISSUE BEFORE THIS COURT IS SUBJECT TO DE NOVO REVIEW.

A question of statutory interpretation is subject to *de novo review*, as are issues involving the grant or denial of a motion for summary disposition. *Kreiner v Fischer,* 2004 Mich Lexis 1563; 683 NW2d 611 (2004); *Roberts v Mecosta Co Gen Hosp,* 466 Mich 57, 62; 642 NW2d 663 (2002).

II. THE *ADVOCACY ORGANIZATION* DECISION IS INCONSISTENT WITH THE LANGUAGE OF THE STATUTE AND CONFLICTS WITH PRIOR APPELLATE PRONOUNCEMENTS INTERPRETING THE REASONABLE AND CUSTOMARY CHARGE LANGUAGE OF THE NO-FAULT ACT.

In enacting the No-Fault Act, the Legislature unambiguously directed that no-fault providers be reimbursed on the basis of their reasonable and customary charges. Section 3105 requires insurers to pay personal protection insurance benefits "for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle ..." MCLA 500.3105.

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[3] *See e.g.,* P.A. 1993, No. 143, discussed at pp 17-22, *infra.* A petition drive placed P.A. 1993, No. 143 before Michigan voters, where it was soundly defeated.

Section 3107 identifies the personal protection insurance ("PPI") benefits payable to the insured including, in subsection (1)(a):

> [a]llowable expenses consisting of all *reasonable charges* incurred for *reasonably necessary* products, services and accommodations for an injured person's care, recovery, or rehabilitation.

MCLA 500.3107 (emphasis added). In its most recent decision interpreting the No-Fault Act, this Court recognized that:

> the injured person's insurance company is responsible for all expenses incurred for medical care, recovery, and rehabilitation as long as the service, product or accommodation is reasonably necessary and the charge is reasonable. MCL 500.3107(1)(a). There is no monetary limit on such expenses, and this entitlement can last for the person's lifetime.

Kreiner v Fischer, 2004 Mich Lexis 1563, *4.[4]

Section 3157 establishes the charges that must be paid and addresses the reasonableness requirement:

> *A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person* for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may *charge a reasonable amount* for the products, services and accommodations rendered. The charge shall not exceed the amount *the person or institution customarily charges* for like products, services and accommodations in cases not involving insurance.

MCLA 500.3157 (emphasis added).

Section 3157 has repeatedly been found to be clear and unambiguous. *See e.g., Johnson v Michigan Mutual Insurance Co,* 180 Mich App 314, 321-322; 446 NW2d 899 (1989). As a result, numerous Court of Appeals' decisions have adhered to the plain meaning

[4] This Court has said that three factors must be met before an item is an allowable expense: (1) the charge must be reasonable, (2) the expense must be reasonably necessary, and (3) the expense must be incurred. *Nasser v Auto Club Insurance Association,* 435 Mich 33, 50; 457 NW2d 637 (1990).

of the statute and have consistently *prohibited insurers* from paying providers according to the panoply of maximum fee schedules the insurers sought to impose. These decisions have consistently upheld the provider's right to establish a level of reimbursement commensurate with the provider's customary charges, rejecting attempts by insurers to impose reimbursement schedules that are not significantly different from what *Advocacy Organization* has allowed here.

Johnson v Michigan Mutual Ins Co, supra, is illustrative. In *Johnson,* the defendant no-fault insurer argued that the trial court erred in ordering the payment of the hospital's customary charges rather than the amounts Medicaid would have paid had plaintiff not been injured by an automobile. The Court of Appeals disagreed:

> We find this an untenable position in light of the unambiguous statutory language of MCL 500.3157; MSA 24.13157, (footnote omitted) which clearly *permits health care providers such as Southfield Rehabilitation Hospital to charge reasonable amounts not exceeding their customary charges* for the products, services and accommodations they provide to other injured persons in cases not involving insurance.
>
> . . .
>
> The no-fault act was designed to afford prompt and adequate reparation for economic losses, such as medical expenses, incurred by individuals in motor vehicle accidents. (Citation omitted). Where, as here, the language of a statute is clear and unambiguous, judicial construction is neither required nor permitted; such a statute must be applied and not interpreted, since it speaks for itself. (Citations omitted).

180 Mich App at 321-322 (emphasis added)(footnote omitted).

The same point was made in *Hofmann v Auto Club Ins Ass'n,* 211 Mich App 55, 113; 535 NW2d 529 (1995), an action by two chiropractors against a no-fault insurer to recover for services and products provided to the defendant's insureds. The insurer counterclaimed, alleging in part that the chiropractors had overcharged for certain services by charging more in

cases involving no-fault insurance than they charged for services payable by health insurers. The Court of Appeals rejected the assertion, relying upon the distinction between health insurers and no-fault insurers discussed by this Court in *Auto Club Insurance Ass'n v New York Life Ins Co,* 440 Mich 126, 139; 485 NW2d 695 (1992):

> One way of containing [health care] costs is for an insurer to place dollar limits upon the amounts it will pay to doctors and hospitals for particular services. *While health and accident carriers generally are free to establish such limits, a no-fault insurer is not. Only the statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier for covered medical expenses.*

211 Mich App at 81 (quoting *Auto Club*) (emphasis added).

Numerous other cases have held accordingly. In *Munson Medical Center v Auto Club Ins Ass'n,* 218 Mich App 375; 554 NW2d 49 (1996), plaintiff sued defendant ACIA to recover its reasonable and customary charges for services rendered to no-fault insureds after ACIA stopped paying the full amount of Munson's bills and *began paying pursuant to a workers compensation fee schedule.* The Trial Court granted summary disposition in favor of Munson and, relying upon the statutory language and the decision in *Hofmann,* the Court of Appeals affirmed.

The no-fault insurer in *Mercy Mt. Clemens Corp v Auto Club Ins Ass'n,* 219 Mich App 46; 555 NW2d 871 (1996), also attempted to impose the workers compensation fee schedule upon the plaintiff provider. To support that level of payment, the insurer sought discovery regarding the hospital's charges to Medicare, Medicaid, Blue Cross, workers' compensation insurers, HMOs, PPOs, etc. In response to the hospital's assertion that such information was irrelevant, the insurer argued that amounts accepted from other payors for the same medical services was relevant to determine the hospital's *reasonable and customary* charges. The Trial Court and the Court of Appeals *disagreed.* The Court of Appeals explained:

> [T]his Court has rejected the arguments of no-fault insurers that they should be obligated to pay only the amount previously accepted as payment in full under Medicaid where Medicaid benefits were mistakenly made on behalf of a patient whose injuries were covered by no-fault insurance. *Hicks v Citizens Ins Co of America,* 204 Mich. App. 142, 146; 514 N.W.2d 511 (1992); *Johnson v Michigan Mutual Ins Co,* 180 Mich. App. 314, 321-322; 446 N.W.2d 899 (1989) (footnote omitted). In *Johnson,* this Court found that the insurer's argument that the hospital's charges could only approximate those payable by Medicaid was 'an untenable position in light of the unambiguous statutory language of [§ 3157], *which clearly permits health care providers . . . to charge reasonable amounts not to exceed their customary charges in cases not involving insurance.' Id.*

219 Mich App at 53 (emphasis added).

Similarly, in *Hicks v Citizens Ins Co,* 204 Mich App 142; 514 NW2d 511 (1994), plaintiff was hospitalized and treated at Children's Hospital on two separate occasions. Citizens fully paid the billed amount for the first hospitalization, but Children's Hospital mistakenly billed the Department of Social Services ("DSS") for Medicaid benefits to cover the second hospitalization. DSS paid its allowable amount and sought and received reimbursement from Citizens. Children's then sought the remainder of the medical bill from Citizens, i.e. the amount that exceeded DSS' allowable Medicaid payment. Citizens refused to pay the balance, asserting that the payment of Medicaid benefits on behalf of plaintiff discharged any responsibility for further payment. The Court of Appeals disagreed, concluding that any agreement between Children's and DSS to limit its claim to the amount allowed for Medicaid benefits was unlawful and could not be relied upon by Citizens to avoid its obligation to pay reasonable and customary medical expenses. The Court explained:

> The fact that, with hindsight, Medicaid benefits were mistakenly paid on plaintiff's behalf does not release plaintiff's responsibility for the medical expenses incurred but not paid for, nor does it bind Children's to limit its claim to the statutory amount allowed for Medicaid benefits. (Citation omitted) . . . Citizens is obligated to pay PIP benefits to or on behalf of plaintiff, including reasonable and customary medical expenses. MCL 500.3112; MSA 24.13112; *Commire v Automobile Club of Michigan Ins Group,* 183 Mich App 299, 302;

454 NW2d 248 (1990). Consequently, Citizens is required to pay plaintiff for the reasonable and customary medical expenses incurred by her at Children's.

204 Mich App at 146.[5]

The Court of Appeals in *Bombalski v Perri,* 247 Mich App 536, n 3, 545; 637 NW2d 251 (2001), recently described several of the above cases as requiring that no-fault carriers pay providers the amounts customarily charged in cases not involving insurance, *rather than amounts the no-fault insurers determined to pay according to various fee schedules.* The Court of Appeals said:

> The no-fault insurer in each of these cases sought to limit the amounts it paid to medical providers according to fee schedules utilized by other insurance companies or under the Worker's Disability Compensation Act. *Munson,* 218 Mich. App. at 378; *Hofmann,* 211 Mich. App. at 114. Both cases involved the interpretation of the term "customary charges" within MCL 500.3157. This Court in each case concluded that in situations where no other health or accident coverage existed, the no-fault insurer could not refer to amounts paid by other insurance companies, Medicare, Medicaid or worker's compensation as a benchmark for determining the amounts of its own payments of customary charges under § 3157. This Court observed that while other fee schedules were limited by contract or various federal and state statutes, the no-fault statute governed no-fault carriers' payments and required them to pay amounts customarily charged in cases not involving insurance. *Munson,* 218 Mich.App. at 383-385; *Hofmann,* 211 Mich. App. at 113-114.

The directive of these decisions is clear. First, the charges for services to no-fault insureds are to be made by the provider, not the no-fault insurer. Second, the charges cannot be limited by insurer-imposed fee schedules. The *Advocacy Organization* decision, which

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[5] "Customary charge" has been interpreted to mean the original amount billed on behalf of every patient treated, as opposed to the amount of payment the provider accepts on behalf of the patient. *See e.g., Mercy Mt. Clemens Corp v ACIA,* 219 Mich App at 52-55 and cases cited therein. Further, "'cases not involving insurance' means those situations where there is literally no 'insurance' in the lay sense of the term - - no Medicare, no Medicaid, no BCBSM and so forth." *Munson v Auto Club Ins. Assoc.,* 218 Mich App at 390.

gives insurers, not providers, the right to determine charges and which allows for the imposition of maximum fee schedules, is therefore totally at odds with the statute.

Defendants have attempted to distinguish the above cases by arguing that they address the "customary" prong of the provider charge requirement, not the "reasonableness" of the charge. However, not all of the cases can be so limited. *See e.g., Johnson v Michigan Mutual Ins Co,* 180 Mich App at 321-322 (finding defendant no-fault insurer's position untenable "in light of the unambiguous statutory language ... which clearly permits health care providers ... to charge reasonable amounts not exceeding their customary charges..."); *Hicks v Citizens Ins Co,* 204 Mich App at 146 ("Citizens is required to pay plaintiff for the reasonable and customary medical expenses incurred by her at Children's"); *Mercy Mt. Clemens Corp v Auto Club Ins Ass'n,* 219 Mich App at 53 (quoting *Johnson*). Indeed, the Sixth Circuit decision in *Advocacy Organization, repeatedly relied upon by Defendants*, described *Mercy Mt. Clemens* as reiterating and reaffirming the holdings in *Munson* and *Hofmann* "by rejecting an insurer's argument that it was entitled to discovery concerning a health care provider's receipt of payments from Medicare, Medicaid, Blue Cross, workers' compensation, HMOs, and PPOs so it could show the *unreasonableness* of the provider's bills." *Advocacy Organization for Patients and Providers v Auto Club Insurance Association,* 176 F3d 315, 321 (6th Cir 1999)(emphasis added).

Other cases that Defendants, the Trial Court and the Court of Appeals rely upon do not have the legal significance accorded them. Indeed, although these cases permit the insurer to refuse to pay a provider's charge ostensibly based upon the statute's requirement that the providers' charges be reasonable, the verbiage relied upon does not state the holding of the cases. *See e.g., McGill v Automobile Ass'n of Michigan,* 207 Mich App 402; 526 NW2d 12

(1994); *LaMothe v Auto Club Ins Ass'n,* 214 Mich App 577; 543 NW2d 42 (1995). In *McGill*, where plaintiffs argued that defendant insurers wrongfully used the workers compensation payment schedules to determine a reasonable payment, the Court's discussion regarding the insurer's right to refuse to pay more than a reasonable charge was essentially dicta. The Court affirmed the grant of summary disposition for defendants because the record revealed "no evidence that plaintiffs have suffered injury as a result of defendants' partial payment of their medical bills; nor is any injury threatened." 207 Mich App at 407. The Court of Appeals said:

> Where no case or actual controversy exists, the circuit court lacks subject-matter jurisdiction to enter a declaratory judgment. *Shavers v Attorney* General, 402 Mich. 554, 588; 267 N.W.2d 72 (1978). A case or actual controversy does not exist where the injuries sought to be prevented are merely hypothetical; there must be an actual injury or loss. *Id.* Therefore, we hold that the trial court properly granted defendants' motions for summary disposition.

Id. In reaching its decision in *LaMothe*, the Court relied on *McGill*. *LaMothe* states:

> The *McGill* court concluded that the insureds had suffered no damages resulting from the insurers partial payment of medical bills. *Id.* at 407. The same situation pertains here and *McGill* is dispositive.

214 Mich at 581.

It would make no sense for the Court to prohibit the use of maximum fee schedules as violative of the "customary" charge language of the statute but permit such schedules to be imposed under the "reasonable" charge requirement. The language of the cases, deferring as they do to the providers' right to charge a reasonable amount that does not exceed the provider's customary fe, cannot now be held to mean something else because the emphasis is on what is reasonable. The *Advocacy Organization* decision attempted to distinguish the 80th percentile schedule from the rejected fee schedules, stating:

> Defendants have not employed the worker's compensation payment schedule which was rejected in *Munson, supra,* to determine whether a particular charge is reasonable. Nor have defendants utilized the amounts insurers have paid for a

> service, which basis was rejected for purposes of determining a "customary" charge in *Munson* and *Hofmann*. Rather, defendants Auto Club Insurance Association (ACIA) and Review Works, for example, employ the "80th percentile test."

257 Mich App at 381-382. This attempt to dismiss the importance of *Munson, Hofmann,* and other similar cases lacks substance. The Court does no more than make a distinction between the 80th percentile test and the others. It does not state the basis for the distinction or explain why the purported distinction commands a different result. Thus, the distinction is illusory and completely lacking in merit.

The 80th percentile scale is in fact a maximum fee schedule that differs only in degree from the BCBSM, Medicaid, and workers' compensation fee schedules that the Court of Appeals prohibited in the no-fault context. [6] The Court of Appeals described it as a test under which 100% of the charge is recommended for payment "as long as the charge does not exceed the highest charge for the same procedure *charged* by eighty percent of other providers rendering the same service." The Court thus concluded that although the 80th percentile test is a formula, it is a formula "based on a survey of *charges* by other health-care providers for the same services, a sampling which we conclude is not prohibited by the statute for determining

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[6] In addition to the 80th percentile system, which is in all respects, a maximum fee schedule, evidence submitted in the Trial Court demonstrates that even entities that do not use the 80th percentile system determine reasonableness by comparing the charge to the very fee schedules rejected by the Court of Appeals in the No-Fault context. *See e.g.*, Memorandum of Linkage Enterprises, Inc. explaining its audit findings and stating, "In addressing the issue of "reasonableness", as dictated by Michigan No-Fault law, the highest identifiable reimbursement within documented fee schedules from across the United States are those amounts identified on the attached graph sheet." Plaintiff-Appellants' Appendix ("Pl/App") at 117a; ManageAbility's Determination of Reasonable and Customary Charges document, which states "ManageAbility uses several different sources of data to identify reasonable and customary medical fees. Among these are the HIAA (Health Insurance Association of America) tables, various health plan reimbursement schedules such as Blue Cross Blue Shield of Michigan, SelectCare, Health Alliance Plan (HAP), and the Michigan Workers' Compensation Fee Schedule." Pl/App at 135a.

the reasonableness of charges for the same service." 257 Mich App at 382. This myopic reasoning is unpersuasive. There is nothing in the *Advocacy Organization* decision which justifies the deference given to the 80th percentile breed of maximum fee schedules in light of the long line of cases that expressly prohibit maximum fee schedules in the No-Fault context.

Further, in its deference to the charges of other providers, the 80th percentile scale wholly disregards the provider's *customary charge for services not involving insurance*, the only factor expressly linked by the statute to the reasonableness of a provider's charge. Thus, the decision effectuates a disconnect between the reasonable and customary charge requirements of the provider's fee. The holding that the customary fee does not define what is reasonable but is simply a cap on what may be charged goes too far. The juxtaposition of the "reasonable" and "customary" factors in the statute implies that the reasonableness of the fee is to be determined, at least in part, by the provider's customary charge. Indeed, the *Advocacy Organization* decision insists that "a charge that is more than that charged to an uninsured person, would, by necessity, be unreasonable because of the limitation in §3157." 257 Mich App at 377, n 3. Likewise, the fact that a charge does not exceed the provider's charge to an uninsured person should carry the diametrical presumption that the charge is reasonable.

Whether the customary and reasonable factors are legally distinct is, at any rate, an issue of semantics because it is quite clear that the industry treats them as one and the same. Thus, although Defendants-Appellees have asserted that "reasonableness is an entirely separate criterion from the customariness" of a charge,[7] the assertion is belied by the review companies' explanation of their approval process. For example, ManageAbility touts a document entitled

[7] Transcript of Hearing on Motion for Discovery Protective Order ("TR on Discovery"), at 22, Pl/App 142a ("As I indicated, it is our position that the case law and statute do demonstrate that reasonableness is an entirely separate criterion from the customariness.").

"DETERMINATION OF REASONABLE AND CUSTOMARY CHARGES" as an "explanation which justifies our recommendation for reasonable and customary levels of payment."[8] This document does not prescribe one set of criteria to determine the reasonableness of a charge and a second set of criteria to determine whether it is customary. The factors are addressed by the same criteria. The document states:

> ManageAbility uses several different sources of data to identify reasonable and customary medical fees. Among these are the HIAA (Health Insurance Association of America) tables, various health plan reimbursement schedules such as Blue Cross Blue Shield of Michigan, SelectCare, Health Alliance Plan (HAP), and the Michigan Workers' Compensation Fee Schedule. Most importantly, we collect and analyze billing data from peer providers for like procedures throughout the state of Michigan.
>
> ManageAbility compares provider charges against all of these data sources and then recommends reimbursements that are slightly higher than those of the group health plans, but certainly in line with their peers' average charges ...[9]

The singular nature of the reasonable and customary inquiry is confirmed in the affidavit of Auto Club's attorney, David Lanctot, who testified:

> For non-hospital providers, Manageability [sic] used various criteria, such as current reimbursement levels for like procedures from various insurance companies, relative values for physicians, HIAA tables, and direct input from peers, *to establish the reasonable and customary fees.* [10]

The same is true of Citizens. The Affidavit of Lois Yardley states:

> Citizens bases its determination of *the reasonable and customary fee* for a non-fault medical service on the database supplied by Health Insurance Association of America.[11]

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[8] Correspondence to Dr. Kenyon, PL/App 133a-135a.

[9] *Id.*

[10] Lanctot Affidavit at ¶ 4 (emphasis added).

[11] Affidavit of Lois Yardley at ¶ 5 (emphasis added).

The *Advocacy Organization* decision thus reads some words in and some words out of Section 3157, contrary to the rules of statutory construction described by this Court in *Roberts v Mecosta Co General Hospital,* 466 Mich 57, 63; 642 NW2d 663 (2002):

> An anchoring rule of jurisprudence and the foremost rule of statutory construction, is that courts are to effect the intent of the Legislature. *People v Wager,* 460 Mich 118, 123 n7; 594 NW2d 487 (1999). To do so, we begin with an examination of the language of the statute. *Wickens v Oakwood Healthcare System,* 465 Mich 53, 60; 631 NW2d 686 (2001). If the statute's language is clear and unambiguous, then we assume that the Legislature intended its plain meaning and the statute is enforced as written. *People v Stone,* 463 Mich 558, 562; 621 NW2d 702 (2001). A necessary corollary of these principles is that a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself. *Omne Financial, Inc v Shacks, Inc,* 460 Mich 305, 311; 596 NW2d 591 (1999).

The No-Fault Act is the "rule book" for deciding questions relating to the payment of personal injury protection benefits, *Rohlman v Hawkeye-Security Ins Co,* 442 Mich 520, 525; 502 NW2d 310 (1993), and when the Act prescribes the mechanism to be followed regarding the payment of no-fault benefits, an insurer may not establish a conflicting mechanism. *See e.g., Cruz v State Farm Mutual Automobile Ins Co,* 466 Mich 588; 648 NW2d 591 (2002). Nor may the appellate court, as the Court of Appeals recently confirmed in *Michigan Chiropractic Council v Commissioner of the Office of Financial and Insurance Service,* 2004 Mich App Lexis 1357 (June 1, 2004).

In *Michigan Chiropractic,* the Court of Appeals properly held that the statutory framework of the No-Fault Act was violated by a managed care No-Fault policy that *required insured's to seek treatment from providers who participated in the insurer's preferred provider network and which paid those providers at reduced rates.*[12] The Court of Appeals explained:

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[12] The No-Fault PPO was created and sold by Farmers Insurance Exchange, one of the Defendants in this action.

> Managed care, in the form of a limited provider network, clearly was not contemplated in the no-fault range of choice system for medical benefits prescribed by § 3107. Farmers' system of PPO - limited medical benefits inherently conflicts with Michigan's no-fault act.

2004 Mich App Lexis 1357, *26. The Court of Appeals further properly noted that the severe penalties the Farmers' PPO imposes when an insured obtains out-of-network services "clash with no-fault precepts, and further convince us that the endorsement must be rejected as inharmonious with the no-fault regime established by the Legislature." *Id.* at *25. The Court added:

> Managed care, and in particular, the PPO option at issue, fundamentally alters the essential premise of Michigan no-fault insurance and is inconsistent with the no-fault act general benefit provisions. Incorporating managed care in to the no-fault scheme, however beneficial or desirable from a policy standpoint, cannot emanate from the innovations of insurance companies or the courts, but only from the Legislature itself.

Id. [13] *See also, Sprague v Farmers Ins Exch,* 251 Mich App 260, 271-272; 650 NW2d 374, 379 (2002)(where the insured's HMO excluded coverage for chiropractic services, the no-fault insurer was liable to pay for the chiropractic expense to the extent that the charge was reasonable and was for a reasonably necessary service).

The appellate courts of this state have long opposed insurers' attempts to condition the receipt of No-Fault benefits upon the satisfaction of requirements that do not appear in the statute. In *Cruz,* this Court held that a no-fault policy provision requiring an insured to submit to an examination under oath ("EUO") as a condition precedent to receipt of no-fault benefits

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[13] Judge White observed in a concurring opinion that under Farmers' PPO, "the insured only receives the full benefits mandated by the act if services are obtained from a managed-care provider." If services are sought from a non-managed care provider, "a deductible that exceeds the amount permitted under the statute is incurred, *and the amount to be paid for the reasonably necessary service will not be the reasonable charge, as required by statute, but the amount under the carrier's usual and customary fee schedule.*" 2004 Mich App Lexis 1357, *28-*29 (emphasis added).

was unenforceable because it imposed greater obligations upon the insured than did the No-Fault Act. The Court explained:

> [W]e conclude that an EUO that contravenes the requirements of the no-fault act by imposing some greater obligation upon one or another of the parties is, to that extent, invalid. Thus, a no-fault policy that would allow the insurer to avoid its obligation to make prompt payment upon the mere failure to comply with an EUO would run afoul of the statute and accordingly be invalid.

466 Mich at 598.

In *Kallabat v State Farm Mutual Automobile Insurance Co*, 256 Mich App 146; 662 NW2d 97 (2003), defendant asserted that the plaintiff in a first-party benefits case had to offer *direct evidence from the treating physician* that the expenses incurred were both reasonable and reasonably necessary in order for plaintiff to prevail. The Court of Appeals rejected this assertion, stating:

> We find no such requirement within the language of the statute, and we cannot find, and defendant does not cite, any binding precedent in this regard.

256 Mich App at 151. *See also, DAIIE v Higginbotham*, 95 Mich App 213, 221; 290 NW2d 414 (1980)("Where an insurance policy contains an exclusionary clause that was not contemplated by the Legislature, that clause is invalid and unenforceable."); *Lakeland Neurocare Centers v State Farm Mutual Automobile Insurance Co,* 250 Mich App 35, 39-40; 645 NW2d 59 (2002)("MCL 500.3142 does not limit the right to seek penalty interest solely to the injured person and if the Legislature intended to limit the penalty interest provision, it could have done so....[T]he judiciary may not engraft such a limitation under the guise of statutory construction.").

The reimbursement framework authorized by the *Advocacy Organization* decision does not substantively differ from the maximum fee schedules and managed care policies addressed in the above decisions. It confers powers upon insurers and imposes limitations upon providers

that go well beyond the express language of the Act. It blatantly conflicts with decisions reached in analogous cases. And, it leaves providers with no practical recourse on disputed fee issues given the prohibitive cost of litigation for relatively small claims.

Although Defendants argue that they "do not claim that they can unilaterally dictate prices or prevent providers from collecting medical fees," that is, in fact, what the *Advocacy Organization* decision has enabled them to do. Under *Advocacy Organization*, it doesn't matter what the *provider charges* or whether the provider's charge is *customary in cases not involving insurance*. Indeed, the *customary charge* factor is read out of the statute by the *Advocacy Organization* decision because payments made pursuant to the 80th percentile fee standards do not consider, and render irrelevant, a provider's customary charge. Contrary to the language of the statute, which permits the provider to make the charge, *Advocacy Organization* gives deference to what the *insurer will pay*. This constitutes a fundamental change in the thrust of the statute and a departure from the law as it previously existed.

Even the *Advocacy Organization* decision recognizes that the amount paid by the insurer must be "based on a *proper determination* of what is reasonable." (emphasis added). The 80th percentile system and the others like it do not result in "proper determinations" of reasonableness. The Court of Appeals erred. Reversal is required.

III. THE DEFEAT OF MAXIMUM FEE SCHEDULE AMENDMENTS TO THE NO-FAULT ACT CONTAINED IN 1993 PA 143 AND PRIOR LEGISLATION EVIDENCES THE ABSENCE OF AUTHORITY IN THE PRESENT STATUTE FOR THE FEE SCHEDULES PERMITTED IN *ADVOCACY ORGANIZATION*

As numerous Court of Appeals decisions have recognized, the No-Fault Act does not permit insurers to impose maximum fee schedules on providers. This conclusion is supported by the Legislature's repeated but failed attempts to impose maximum fee schedules by

statutory amendment. After Governor Engler's veto of legislation amending various provisions of the No-Fault Act in 1992,[14] an initiative petition to amend the act placed the issue before the voters. One of the proposed provisions would have amended Section 3107 to impose reimbursement fee schedules similar to those used under the Workers Disability Compensation Act. It provided:

> Allowable expenses shall not exceed the maximum amount a health care facility or provider is entitled to be paid or reimbursed for treatment, service, accommodation, and medication pursuant to the fee schedules contained in R418.101 to R418.2324 of the Michigan Administrative Code. The Commissioner shall, as soon as practical, develop rules to establish schedules of maximum fees or charges for use under this subsection which shall not exceed the maximum fees or charges established in R418.101 to R418.2324 and may adjust his or her own schedules from time to time as may be required.

Proposed Section 3107(4).[15] The referendum was defeated by the voters. Thereafter, the Legislature enacted 1993 PA 143 ("Act 143").

Among other revisions, Act 143 made substantial changes to MCL 500.3157.[16] For example, under subsection (1), the provider's charge for services rendered to an injured person was not to exceed the amount the provider "customarily charges *and accepts as payment in full"* for services provided in cases "not involving *personal protection insurance."* Section 3157(1) of Act 143 (emphasis added).[17] The provision stated:

> Subject to subsections (2) and (3), a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or

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[14] *See* Text of Senate Bill 691, Pl/App at 75a-77a; Veto Message, Pl/App at 79a-83a.

[15] *See* Initiative Petition, Pl/App at 86a.

[16] *See* 1993 PA 143, Pl/App at 97a-99a.

[17] This was the result argued for by insurers in many of the cases addressed above.

> institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services, and accommodations rendered. The charge to an injured person or his or her personal protection insurer shall not exceed the amount the person or institution customarily charges and accepts as payment in full for like products, services, and accommodations in cases not involving personal protection insurance.

This differs significantly from the present statute, which merely requires that the charge not exceed the amount customarily charged in cases not involving insurance. The present statute directs that the charges authorized by Section 3157 are those originally billed by providers, not the amounts accepted. Further, "in cases not involving insurance" has been interpreted to mean no insurance at all, rather than no no-fault insurance. *See* p 8, fn 5, *supra*.

Act 143 also added subsections (2) and (3) to Section 3157, prescribing maximum fee schedules for provider charges. The provisions stated in pertinent part:

> (2) By not later than 90 days after the effective date of the amendatory act that added this subsection and continuing until a schedule of fees is implemented pursuant to subsection (3), a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury are limited to, and shall be paid by the automobile insurer at, either of the following as selected by the provider:
>
> (a) The amount paid for treatment service, accommodation, and medicine pursuant to payment under, or schedules of maximum fees for worker's compensation contained in, R 418.01 to R 418.2324 of the Michigan administrative code.
>
> (b) For a health care facility, 113% of the ratio of a participating health care facility's costs to its charges for the prior calendar year as used in the development of reimbursement to that provider by a payor authorized under the nonprofit health care corporation reform act, Act. No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, multiplied by the prior calendar year's charges for

> specific automobile accident injury treatments, services, accommodations, and medicines. For a health care provider 110% of the amount paid for treatment, services, accommodation, and medicine pursuant to schedules of maximum fees issued by a payer authorized under Act No. 350 of the Public Acts of 1980. For facilities in a provider class plan where controlled charges are paid by a nonprofit health care corporation, controlled charges shall also be paid by automobile insurers…
>
> (3) The commissioner shall establish schedules of fees pursuant to rules promulgated by the administrative procedures act of 1969, Act. No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that a physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance and a person or institution providing rehabilitative occupational training following the injury shall be limited to for reimbursement...

Subsection (7), requiring a health care facility or provider to accept the amount reimbursed under subsections (2) and (3) as payment in full, was also added. A new Subsection (9) allowed health care facilities or providers to contract with insurers for other reimbursement levels, and new subsections (4)–(6) provided for a utilization review system that was required to be implemented unless an automobile insurer could demonstrate that it would not be cost effective.[18]

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[18] With Act 143, the Legislature enacted § 3104a to create a task force to implement a cost reduction plan examining the use of "managed care, preferred provider arrangements, case management, treatment protocols, utilization review, rehabilitation, and other contractual arrangements." The Legislature also enacted §3104b to permit automobile insurers to use clinical care management for each insured whose personal protection insurance benefits were not expected to exceed a specified dollar amount, and to require clinical care management for insureds whose PPI benefits were expected to exceed the specified dollar amount. Section 3107 was simultaneously amended to provide "benefits … for … [a]llowable expenses … incurred for medically appropriate products, services, and accommodations for an injured person's care, recovery or rehabilitation." It also set up an internal review scheme to deal with disputes regarding medical appropriateness and medical necessity. *The present § 3107 requirement that insurers pay "all reasonable charges incurred for reasonably necessary products, services and accommodations" was deleted.*

Although Act 143 was enacted by the Legislature, it never took effect. Opponents of the no-fault amendments succeeded in placing Act 143 on the general election ballot, where it was soundly defeated by the voters. The Editor's notes following Section 3157 and other sections of the No-Fault Act state:

> Pub Acts 1993, No. 143, intending to amend this section, was to take effect 90 days after the close of the legislative session, or April 1, 1994. However, upon the submission of the requisite number of signatures, the effectiveness of Pub Act No. 143 was suspended pending outcome of a referendum, pursuant to the decision in *Farm Bureau Mutual Ins. Co. of Michigan v. Commission of Insurance* (March 28, 1994) 204 Mich App 361, 514 NW2d 547, 8 Mich L. W. 693. At the election held on Nov. 8, 1994, the referendum was defeated, therefore Pub Act No. 143 did not take effect.

It is well-settled that legislative amendments are presumed to change the state of existing law. *See e.g., People v Price,* 124 Mich App 717, 721; 335 NW2d 134 (1983). No change can be presumed to be without purpose. Rather, "when the Legislature adopts an amendment to a statute, it is presumed that the Legislature intended to make some change in existing law." *English v Saginaw County Treasurer,* 81 Mich App 626, 631; 265 NW2d 775 (1978). Such a change must be presumed here. If insurers were permitted to limit provider charges according to imposed fee schedules under the present statute, the proposed amendments would have been unnecessary.

These failed legislative proceedings influenced the Court's decisional process in *Munson, supra,* where the Court of Appeals observed that having failed to obtain the legislative result it desired, the no-fault insurer unlawfully presumed to accomplish the result unilaterally. The no-fault insurer, ACIA, who is also a defendant in this case, unilaterally reduced its no-fault payments to hospital providers after its repeated attempts to amend the No-Fault Act to allow for reduced fee schedules, were defeated. The Court rejected ACIA's attempt to side-step the law, stating:

> In 1992, ACIA sought passage of a referendum, Proposal D, which would have permitted ACIA to pay no-fault claims according to fee schedules (and which required ACIA to reduce its premiums). Proposal D was soundly rejected. Again in 1994, ACIA attempted to obtain passage and approval of similar amendments, which would have expressly incorporated the worker's compensation fee schedules[6] with an accompanying premium rollback. Again the effort was unsuccessful. Despite its failure to obtain an amendment of the no-fault law, ACIA nonetheless unilaterally implemented the result it wanted. ACIA's use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law.
>
> [6] Proposal C would have provided for payment of charges at the greater of the worker's compensation rates or 110 percent of BCBSM rates.

218 Mich App at 390.

In enacting the subsequently-rejected amendments, the Legislature recognized that it was necessary to amend the No-Fault Act if insurers were to be allowed to impose maximum fee schedules on provider charges because the No-Fault Act, as it then existed (and as it exists now), did not otherwise permit it. The amendments failed. Thus, there should be no question regarding the current status of the law. The 80th percentile test is, in fact, a fee schedule. *Advocacy Organization* is thus a radical departure from governing case law and the plain language of the No-Fault Act. Reversal is requested.

IV. THE 80TH PERCENTILE TEST DOES NOT MEASURE REASONABLENESS.

One thing could not be clearer. The 80th percentile test approved by the *Advocacy Organization* decision does not measure reasonableness. As Plaintiffs-Appellants persuasively argue in their brief, the 80th percentile system "automatically defines 20 percent of providers' charges as 'unreasonable,' no matter how much, or how little, they are." Plaintiffs-Appellants' Brief on Appeal at 25. This sterile assessment runs counter to the individualized inquiry Defendants-Appellees told the Court was required to determine "reasonableness" at the *Advocacy Organization* hearing on the motion for class certification. At that time, apparently

speaking on behalf of Defendants-Appellees collectively, counsel for Citizens Insurance Company and Auto-Owners Insurance Company told the Trial Court that "to look at each provider's bill and say that that particular fee is a reasonable fee for the services provided" ... "gets you exactly into the individualized proof that we have pointed out in our brief." [19] Counsel continued:

> That means they are going to have to show for example that a plastic surgeon is charging a fee for a broken nose that is properly based on that *plastic surgeon's credentials, their area of practice, their, their training, the complexity of the particular service that is being rendered,* and that those factors combined would lead a jury to conclude that that is a reasonable fee for the service provided.[20]

Significantly, at the hearing, Citizens' and Auto-Owners' counsel insisted that what might be a reasonable fee for one physician *"does nothing to prove the case of the next plastic surgeon who has individually set his or her own rates."* [21]

> That plastic surgeon proving that it's reasonable for example to charge $1,000.00 for fixing someone's broken nose does nothing to prove the case of the next plastic surgeon who has individually set his or her own rates ... [22]

This position defeats the entire premise of the 80th percentile system. If rates are not transferable from one provider to the next to prove reasonableness in the litigation context, how can they be not only transferable but *determinative* in the review context?

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[19] Transcript of Hearing on Motion to Certify Class Action dated January 14, 2000 ("TR of Class Motion"), Pl/App. at 37a, 44a.

[20] TR of Class Motion at Pl/App at 44a-45a (emphasis added). A case relied upon by Defendants-Appellants reaches a similar conclusion, reversing the Trial Court's finding that charges for novel brain scan procedures were reasonable and necessary because the issue presented a question of fact for the jury. The Court determined that finding such expenses to be reasonably necessary without regard to the *individual circumstances* of each patient thwarts the policy underlying § 3107. *Spect Imaging, Inc v Allstate Ins Co,* 246 Mich App 568, 577; 633 NW2d 461 (2001).

[21] *Id.*

[22] *Id.*

That individual circumstances are not considered by the 80th percentile system is evident from the evidence submitted by Defendants-Appellees. David J. Lanctot, an attorney purportedly responsible for defending ACIA in suits brought by medical providers, avers that under the 80th percentile test "the provider is paid its full charge, but not more than the highest amount charged for that same service by 80% of the providers throughout the State" and that "the amounts charged by the providers is tracked based upon the uniform procedure codes used by non-hospital providers, called current procedural technology codes, known as "CPT Codes", which are published and updated annually by the American Medical Association as a communication tool ..."[23] Lois Yardley, a senior manager for Citizens Insurance Company of America, similarly testified that Citizens "bases its determination of the reasonable and customary fee for a no-fault medical service on" a database and "reimburses the provider for its full charge, so long as that charge is not more than the highest amount charged for that same service by 80% of the providers within the provider's same geographical area ... as reflected in the computer database." [24] In other testimony, Diane Mateja testified that the "computer" lines up 100 providers under a particular diagnostic code "[a]nd where the 80th one bills is what it determines is the 80th percentile." [25]

This is not the type of reasonableness inquiry that counsel for Defendants-Appellees told the Court was necessary to determine the reasonableness of a provider's fee. It is, in fact, no more than another maximum fee schedule. The *Advocacy Organization* decision is erroneous and must be reversed.

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[23] Affidavit of David J. Lanctot at ¶ 5.

[24] Affidavit of Lois Yardley at ¶ 5.

[25] Deposition of Diane Mateja at p 63-64, Pl/App at 130a..

RELIEF REQUESTED

Amicus Curiae Michigan State Medical Society therefore requests that this Court reverse the Court of Appeals' decision in *Advocacy Organization for Patients & Providers v Auto Club Insurance Association et al.*

Respectfully submitted,

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